(2)

No. 04-1305

Supreme Court, U.S.
FILED
APR 2 8 2005
OFFICE OF THE CLERK

In The
Supreme Court of the United States

KEVIN BALDADO,

Petitioner,

v.

HAWAII MANAGEMENT ALLIANCE ASSOCIATION,

Respondent.

On Petition For A Writ Of Certiorari To The Supreme Court Of Hawai'i

HAWAII MANAGEMENT ALLIANCE ASSOCIATION'S OPPOSITION TO PETITION FOR A WRIT OF CERTIORARI

Of Counsel:
ALSTON HUNT FLOYD & ING
Attorneys at Law
A Law Corporation

ELLEN GODBEY CARSON
Counsel of Record
DIANNE WINTER BROOKINS
18th Floor, ASB Tower
1001 Bishop Street
Honolulu, Hawai'i 96813
Telephone: (808) 524-1800
Attorneys for Respondent

COCKLE LAW BRIEF PRINTING CO. (800) 225-6964
OR CALL COLLECT (402) 342-2831

CORPORATE DISCLOSURE STATEMENT

Respondent Hawaii Management Alliance Association is a non-governmental corporate party, incorporated in the State of Hawai'i. No individual or public company owns ten percent or more of the stock of the company.

TABLE OF CONTENTS

	Page
CORPORATE DISCLOSURE STATEMENT	i
TABLE OF CONTENTS	ii
TABLE OF AUTHORITIES	iii
STATUTES AND CONSTITUTIONAL PROVISIONS INVOLVED	1
COUNTER-STATEMENT	1
REASONS FOR DENYING THE PETITION	6
I. THE QUESTIONS PRESENTED BY THE PETITION WERE NOT RAISED BELOW	6
II. THE PETITION MISREPRESENTS THE OPERATION OF THE HAWAI'I STATUTE AND ITS LEGISLATIVE HISTORY	9
III. THE PROCEEDINGS IN THIS CASE DO NOT REFLECT A CONFLICT BETWEEN THE STATES REGARDING AN IMPORTANT FEDERAL QUESTION	17
CONCLUSION	23

TABLE OF AUTHORITIES

Page

FEDERAL CASES

Aetna Health, Inc. v. Davila, 542 U.S. 200, 124 S. Ct. 2488 (2004) 4, 22

Hummel v. S.E. Rykoff & Co., 634 F.2d 446 (9th Cir. 1980) 3

Ruckelshaus v. Sierra Club, 463 U.S. 680 (1983) 3

Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355 (2002) 8, 9, 10, 19

Standard Oil Co. v. Agsalud, 633 F.2d 760 (9th Cir. 1980), aff'd, 454 U.S. 801 (1981) 5

STATE CASES

Conn. Gen. Life Ins. Co. v. Ins. Comm'r for Md., 371 Md. 455, 810 A.2d 425 (2002) 17, 20

Hawaii Management Alliance Association v. The Insurance Commissioner, et al., 106 Hawai'i 21, 100 P.3d 952 (2004) 1, 10, 17, 20

FEDERAL STATUTES

29 C.F.R. § 2560.503-1 20

29 U.S.C. §§ 1001, *et seq.* 1

29 U.S.C. § 1132(a) 7, 10, 20

29 U.S.C. § 1144 ..... 5, 20

29 U.S.C. § 1144(b)(5) 5

TABLE OF AUTHORITIES – Continued

Page

FEDERAL RULES

Sup. Ct. R. 10 2
Sup. Ct. R. 10(b) 21
Sup. Ct. R. 14(g) 6, 7
Fed. R. Civ. P. 12(b)(6) 14

STATE STATUTES

Haw. Rev. Stat. § 91-9(g) 11
Haw. Rev. Stat. § 91-14 10
Haw. Rev. Stat. § 91-14(a) 10
Haw. Rev. Stat. § 432E-1 18
Haw. Rev. Stat. § 432E-1.4 ..... 8, 16
Haw. Rev. Stat. § 432E-5(a) 16
Haw. Rev. Stat. § 432E-5(d) 8, 18
Haw. Rev. Stat. § 432E-6 ..... *passim*
Haw. Rev. Stat. § 432E-6(a) 12, 18, 19
Haw. Rev. Stat. § 432E-6(a)(2) 11
Haw. Rev. Stat. § 432E-6(a)(4) 10, 13, 15
Haw. Rev. Stat. § 432E-6(a)(6) 15
Haw. Rev. Stat. § 432E-6(a)(7) 12, 13, 15, 16
Haw. Rev. Stat. § 432E-6(b) 17
Haw. Rev. Stat. § 432E-6(e) 3, 14
Haw. Rev. Stat. Ch. 671 17
Md. Ins. Code Ann. § 15-10A-01(b)(1) 18

TABLE OF AUTHORITIES – Continued

Page

Md. Ins. Code Ann. § 15-10A-02(d) 18

Md. Ins. Code Ann. § 15-10A-03 18

Md. Ins. Code Ann. § 15-10A-03(a) 18

Md. Ins. Code Ann. § 15-10A-03(d) 18

Md. Ins. Code Ann. § 15-10A-03(e)(2) 19

Md. Ins. Code Ann. § 15-10A-03(e)(4) 19

Md. Ins. Code Ann. § 15-10A-04(a)(3) 19

MISCELLANEOUS

Gretchen Garrison, *House Bill 335-Managed Care in Missouri,* 66 UMKC L. Rev. 775, 797 (1998) 22

STATUTES AND CONSTITUTIONAL PROVISIONS INVOLVED

Pertinent portions of the statutory provisions relied upon by the Petitioner, which were not included as part of the Petitioner's Appendix ("P. App."), are provided in the Appendix hereto (Respondent's Appendix, or "R. App.").

COUNTER-STATEMENT

There is no need for this Court to grant the Petition for Writ of Certiorari filed March 28, 2005 by Petitioner Kevin Baldado (hereinafter "Petition"). The prior rulings of this Court regarding federal preemption of state laws by the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001, *et seq.* ("ERISA") provide all the guidance required to determine the validity of the Hawai'i external review statute, Haw. Rev. Stat. § 432E-6,[1] and other state laws described by the Petition as "active enforcement" statutes. Petition at 14. The Hawai'i Supreme Court properly applied the ERISA jurisprudence of this Court in its decision in *Hawaii Management Alliance Association v. The Insurance Commissioner, et al.*, 106 Hawai'i 21, 100 P.3d 952 (2004) ("*HMAA*"). That decision does not conflict with the cited decision of the Maryland court of last resort, as the Petition asserts, because the Hawai'i and Maryland statutes have significant differences. Moreover, the Maryland court did not perform the same conflict preemption analysis performed by the Hawai'i court. *See* the discussion *infra* at Section III of the Reasons for Denying the

[1] P. App. at 47a-50a. Haw. Rev. Stat. § 432E-6 is referred to herein as "the Hawai'i statute."

Petition. Petitioner has not established the "compelling reason" required for a writ of certiorari to issue, Sup. Ct. R. 10, and the Petition should be denied.

There is no need for this Court to review the Hawai'i court's decision. Respondent Hawaii Management Alliance Association (hereinafter "HMAA") properly denied coverage for the nonmyeloablative stem cell transplant (bone marrow transplant) sought by Petitioner Kevin Baldado (hereinafter "Petitioner" or "Baldado"). Baldado relied on a single medical journal article as scientific support for the proposed treatment. The article, however, merely reviewed the results of an investigation involving 19 patients and ultimately concluded that the proposed treatment "should remain an investigational approach for the treatment of metastatic renal cell carcinoma." Agency Record on Appeal ("AROA") at 37. It further noted that "additional patients will need to be treated" and "additional patients and more time will be required" to determine the efficacy of the treatment. *Id.* The Hawai'i Insurance Commissioner's panel, convened to review HMAA's decision pursuant to Baldado's request for external review, upheld HMAA's decision. The Commissioner's Order concluded, *inter alia*, that: (1) Baldado's health plan excluded from coverage experimental or investigative therapies; (2) Treatment of advanced renal cell carcinoma with bone marrow transplant was investigational; and (3) HMAA "acted reasonably in denying [bone marrow transplant] treatment for renal cell carcinoma, stage IV, as there is insufficient scientific evidence available at the present time to support the reliability of the requested therapy for [Mr. Baldado's] present condition." Circuit Court Record on Appeal ("ROA") at 294. HMAA did not appeal this decision in its favor, and neither did Baldado. The assertions in the

Petition that Baldado obtained the treatment through other means and regarding his present condition (Petition at 11) are not supported by any evidence in the record.

The appeal through the Hawai'i courts challenged the Commissioner's order requiring that HMAA pay Baldado attorneys' fees, notwithstanding the fact that HMAA had fully prevailed before the Commissioner in the external review process. This Court has characterized the award of attorneys' fees to a non-prevailing party as "a radical departure from established principles requiring that a fee claimant attain some success on the merits before it may receive an award of fees." *Ruckelshaus v. Sierra Club,* 463 U.S. 680, 693 (1983). The interpretation of Haw. Rev. Stat. § 432E-6(e)[2] by the Hawai'i Insurance Commissioner as authorizing the award of attorneys' fees to a non-prevailing party was not only inconsistent with the "established principles" recognized by this Court in *Ruckelshaus*, but was also in direct conflict with ERISA. While ERISA allows for an award of attorneys' fees to either party, the Ninth Circuit has held that attorneys' fee awards may be made only to prevailing parties. *Hummel v. S.E. Rykoff & Co.*, 634 F.2d 446 (9th Cir. 1980) (establishing five factor test). The attorneys' fee provision of the Hawai'i statute also conflicted with ERISA because it allows awards only to the enrollee, and not to the plan. Moreover, the attorneys' fee award was the culmination of an external review process under Hawai'i law, which is entirely preempted by ERISA. On appeal, HMAA argued that ERISA preempted the entirety of the external review statute, Haw. Rev. Stat. § 432E-6, including but not limited to the fee award

[2] P. App. at 50a.

provision in subsection (e). The Hawai'i court correctly concluded that the attorneys' fee provision could not survive the preemption of the remainder of Haw. Rev. Stat. § 432E-6.

There is no support in the record for Petitioner's assertion that "[t]he primary purpose of Hawai'i's external review provision is to invite insureds to submit adverse coverage decisions for the commissioner to review, providing grist for his regulatory mill." Petition at 4. Rather, the Hawai'i external review process is strictly adjudicatory. It provides an alternative process for review of a health plan's benefit determination, including a contested case evidentiary hearing, and authorizes the Commissioner to "issue an order affirming, modifying, or reversing the decision," upon a majority vote of the three member panel assembled to hear the external review. Haw. Rev. Stat. § 432E-6(a)(7).[3] As such, it "provides a separate vehicle to assert a claim for benefits outside of, or in addition to, ERISA's remedial scheme." *Aetna Health, Inc. v. Davila*, 542 U.S. 200, ___, 124 S. Ct. 2488, 2500 (2004) ("*Aetna Health*"), and is preempted.

The discussion in the Petition regarding the Commissioner's ability to reject requests for external review that do not have merit, and the frequency with which he has exercised that discretion, is based on facts that were not a part of the record before the Hawai'i courts. Even if the facts were a matter of public record at the time, that record was not brought to the attention of the Hawai'i courts, so it is not a part of the record on appeal. Petitioner

[3] P. App. at 49a.

did not rely on those facts below, and cannot rely upon them as a basis for this Petition.

Petitioner's discussion of the Hawai'i Prepaid Health Care Act of 1974 ("PHCA"), Petition at 5-6, is not supported by the record in this case, and the impact of the PHCA on the issues in this case, if any, was not argued to the Hawai'i courts. Moreover, the Petition misstates the history of the PHCA. ERISA did not contain an exemption from preemption for the PHCA when it was first enacted. In fact, this Court summarily affirmed the decision of the Ninth Circuit Court of Appeals that the PHCA was preempted by ERISA. *Standard Oil Co. v. Agsalud*, 633 F.2d 760 (9th Cir. 1980), aff'd, 454 U.S. 801 (1981). A subsequent amendment to 29 U.S.C § 1144 created an exemption for the PHCA. 29 U.S.C. § 1144(b)(5)(A). However, any amendment to the PHCA which "provides for more than the effective administration of such Act as in effect on [September 2, 1974]" remains expressly preempted by ERISA. 29 U.S.C. § 1144(b)(5)(B)(ii). Moreover, the exemption for the PHCA was further limited in that it expressly does not apply to any PHCA provisions which conflict with Sections 1 and 4 of Subtitle B of ERISA. 29 U.S.C. § 1144(b)(5)(C). Clearly, neither this Court nor Congress believed that ERISA preemption of conflicting state laws was less of a concern in Hawai'i than elsewhere in the nation, as is asserted in the Petition. While the PHCA imposes a detailed scheme for prepaid health plans to be provided by employers in Hawai'i, the need for consistent procedures and remedies, as provided by ERISA, is as great in Hawai'i as it is anywhere else.

The assertions in the Petition regarding the evolution of the health plan contractor industry in Hawai'i are not supported by any record evidence. Further, the assertion

that the Hawai'i legislature enacted the Patient Bill of Rights and Responsibilities in 1998 "to deal with concerns over the potential for gate-keeping and other abuses" ignores the express language of the preamble to Act 178. In enacting Act 178, the Hawai'i Legislature expressly recognized that "Hawai'i has been fortunate not to experience the questionable practices of certain entities engaging in managed care."[4] The discussion of the work of the task force created by Act 178, Petition at 8-9, is also wholly unsupported by the record, was not argued to the Hawai'i state courts, and thus cannot be relied upon before this Court.

The Petition engages in revisionist history regarding the evolution of Hawai'i's external review law, as is discussed further *infra* in Section II of the Reasons for Denying the Petition.

REASONS FOR DENYING THE PETITION

I. THE QUESTIONS PRESENTED BY THE PETITION WERE NOT RAISED BELOW

The Petition identifies two Questions Presented to this Court. Petition at (i). However, neither of the questions identified in the Petition were properly raised before the state courts. Nor does the Petition comply with the requirements of Rule 14(g) of the Rules of the Supreme Court. The Petition does not specify the stage in the proceedings where the federal questions sought to be reviewed were raised, the manner or method of raising

[4] P. App. at 51a.

them, and the way in which they were passed on by the state courts. Nor does the Petition include pertinent quotations of specific portions of the record where the matter appears, "so as to show the federal question was timely and properly raised and that this Court has jurisdiction to review the judgment on a writ of certiorari." Sup. Ct. R. 14(g).

Petitioner does not make this required showing, because he cannot do so. The basic premise of the first Question Presented by the Petition is that Haw. Rev. Stat. § 432E-6 only "subjects a small number of coverage denials to an adversarial process as part of regulating health plans, but does not provide plan participants a legal right to an independent benefit determination." Petition at (i). The Hawai'i statute was never characterized in that fashion in the proceedings below, nor is there any record evidence to support that characterization. Accordingly, the question of whether a statute so described would "implicate the enforcement scheme of [ERISA] 29 U.S.C.S. § 1132(a) sufficiently to warrant preemption" was never presented to the state courts in the proceedings below. This Court thus has no jurisdiction to review that question.

Similarly, the second Question Presented by the Petition relies upon the premise that "the external review is part of a comprehensive regulatory plan administered by the state agency assigned to police health insurers' compliance with medical necessity and any other state-mandated benefits." Petition at (i). The factual record in this case is devoid of any evidence to support that premise, nor was that argument made to the state courts at any time prior to the filing of Petitioner's motion for reconsideration of the *HMAA* decision. In Appellee Kevin Baldado's

Motion for Reconsideration of the Supreme Court of Hawai'i's Opinion dated November 18, 2004, filed November 29, 2004 ("Motion for Reconsideration"), Petitioner asserted that "§432E-6 is the insurance commissioner's review of the health plan's compliance with §§ 432E-5 and 1.4." Motion for Reconsideration at 6. The Motion for Reconsideration further asserted that, as a result of the Hawai'i court's decision in *HMAA*, "the Insurance Commissioner has no means to enforce §§ 432E-1.4 and 5," *id*, and that "Hawai'i state government has a heightened duty to regulate health care because it forces Hawai'i employers to fund employee health insurance under the Prepaid Health Care Act[.]" *Id*. at 6-7. Those arguments were improperly presented for the first time in the Motion for Reconsideration, and were not supported by any record citations – because there are no facts of record to support them.

Moreover, even if the arguments presented in the Motion for Reconsideration were a proper part of the record on appeal, Petitioner nonetheless failed to preserve for appeal the crux of his second question, "[w]hether the *Rush Prudential* test, providing that external review laws are saved so long as they do not 'so resemble an adjudication as to fall within *Pilot Life*'s categorical bar . . . ' is the appropriate test to apply" to the Hawai'i statute. Petition at (i). Petitioner never argued that *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002) ("*Rush Prudential*") was not the appropriate test to determine ERISA preemption in any of his briefing before the state courts. Rather, Petitioner argued that "a perusal of" this Court's decision in *Rush Prudential* was "all that is needed to reject HMAA's preemption argument." Appellee Kevin Baldado's Answering Brief filed in the Hawai'i Supreme Court on

July 9, 2002, at 11. Petitioner continued to argue the controlling effect of the *Rush Prudential* decision for several pages of his brief before the Hawai'i court. *Id.* at 11-13. Far from questioning the proper application of *Rush Prudential* to the analysis of the Hawai'i statute, Petitioner advocated *Rush Prudential* as controlling law. He cannot now seek review of a question that was never presented to the Hawai'i state courts. For this reason alone, the Petition must be denied.

II. THE PETITION MISREPRESENTS THE OPERATION OF THE HAWAI'I STATUTE AND ITS LEGISLATIVE HISTORY

Petitioner's interpretation of Haw. Rev. Stat. § 432E-6 as providing alternative methods of external review, in addition to the three person review panel, is supported by neither the language nor the structure of the statute. It is a novel interpretation of the statute, which was not argued before the state courts which decided this case. Petitioner's argument has not even been advanced by the Insurance Commissioner – who is charged with implementation of the external review process.[5] Even a cursory review of the statutory language confirms that the external review process under the Hawai'i statute is to be performed by a three-member panel.[6] The decision of the

[5] The Insurance Commissioner and the Division of Insurance, Department of Commerce and Consumer Affairs, State of Hawai'i, filed a letter in support of the Petition on April 8, 2005, and indicated they would participate in this case on the merits if the Petition is granted. However, the Commissioner has never advocated the interpretation of the Hawai'i external review statute argued in the Petition.

[6] The only exception is in cases where the amount at issue is less than $500, in which cases the Insurance Commissioner may conduct a

(Continued on following page)

Commissioner is then subject to judicial review under Haw. Rev. Stat. § 91-14: "any person aggrieved by" the outcome of the contested case hearing "is entitled to judicial review thereof." Haw. Rev. Stat. § 91-14(a).[7] As the Hawai'i court in *HMAA* concluded: "a claimant who is denied benefits pursuant to Hawaii's external review law can appeal that denial to the courts, allowing for a judicial determination of the claimant's entitlement to benefits." 106 Hawai'i at 35, 100 P.3d at 966. That aspect of the Hawai'i statute clearly violates the exclusive civil enforcement scheme of ERISA, 29 U.S.C. § 1132(a).

The adjudicatory review by a three-member panel is the only means of conducting the external review under the Hawai'i statute. As the Hawai'i court held in *HMAA*:

> whereas the Illinois statute considered in *Rush Prudential* required one physician to determine whether the proposed procedure was "medically necessary," the Hawai'i statute provides for a three-member panel (only one of whom must be a physician) to determine whether the HMO's actions were "reasonable." These distinctions are fatal to the external review law. The external review hearing more closely resembles "contract interpretation or evidentiary litigation before a neutral arbiter" than "a practice (having nothing to do with arbitration) of obtaining another medical opinion." *Rush Prudential*, 536 U.S. at 383.

106 Hawai'i at 35, 100 P.3d at 966.

---

hearing himself, without convening a review panel. Haw. Rev. Stat. § 432E-6(a)(4). P. App. at 48a.

[7] P. App. at 84a.

Petitioner's argument that the Hawai'i statute provides alternatives to the adjudicatory review by a three-member panel invites the Court to focus upon subsection (a)(2) of Haw. Rev. Stat. § 432E-6, and ignore the remainder of the statute. Petition at 17. It is true that subsection (a)(2) allows the Commissioner to retain "an independent medical expert trained in the field of medicine most appropriately related to the matter under review." Haw. Rev. Stat. § 432E-6(a)(2)(A).[8] That provision continues, however, to specify that "[p]resentation of evidence for this purpose shall be exempt from section 91-9(g)." *Id.* Clearly, this provision merely allows the Commissioner to present ***evidence*** from this medical expert to the review panel, even though such evidence was not a part of the record provided by the parties and would otherwise be inadmissible. Haw. Rev. Stat. § 91-9(g) provides that, in a contested case proceeding, "[n]o matters outside the record shall be considered by the agency in making its decision[.]"[9] The statutory reference to presenting evidence from a medical expert does not allow the Commissioner to delegate to a medical expert the responsibility for rendering the decision on the external review.

Haw. Rev. Stat. § 432E-6(a)(2)(B) similarly allows the Commissioner to retain the services of an independent review organization ("IRO") to advise the three-member panel: "The Commissioner may retain . . . [t]he services of an independent review organization from an approved list maintained by the commissioner."[10] However, the services of the IRO must be intended merely to advise the three-member

---

[8] P. App. at 47a.

[9] Respondent's Appendix attached hereto ("R. App.") at 1a.

[10] P. App. at 47a.

panel, because there is no authorization in the statute for the IRO to render any "decision." Nor is there any record evidence that the Commissioner maintains an "approved list" of IROs, much less has ever called upon an IRO to assist in the external review function under section 432E-6. Rather, the Hawai'i statute refers only to a decision based upon the vote of the three-member panel. *See* Haw. Rev. Stat. § 432E-6(a)(7) ("The commissioner, upon a majority vote of the panel, shall issue an order affirming, modifying, or reversing the decision" of the managed care plan).[11]

The actual right to external review is expressed in terms of review by a three-member panel:

> After exhausting all internal complaint and appeal procedures available, an enrollee, or the enrollee's treating provider or appointed representative, may file a request for external review of a managed care plan's final internal determination to a three-member review panel appointed by the commissioner.

Haw. Rev. Stat. § 432E-6(a).[12] The statute does not say the request for external review is made to the Commissioner, who will then decide whether the review is to be conducted by a medical expert, an IRO or a three-member review panel. The scope of the external review is also stated in terms of review by the three-member panel: "The review panel shall review every final internal determination to determine whether the managed care plan involved acted

---

[11] P. App. at 49a.

[12] P. App. at 47a.

reasonably." Haw. Rev. Stat. § 432E-6(a)(7).[13] There is no support in the statute or the record for the assertion that the Commissioner has discretion to choose among three alternative settings for the external review. Petition at 15, 17, and 18. Nor was this argument ever presented to the Hawai'i court for its consideration.

Where there is good cause shown for an external review, the statute provides that the Commissioner "shall" appoint a review panel:

> Upon receipt of the request for external review and upon a showing of good cause, the commissioner shall appoint the members of the panel and shall conduct a review hearing pursuant to chapter 91. If the amount in controversy is less than $500, the commissioner may conduct a review hearing without appointing a review panel.

Haw. Rev. Stat. § 432E-6(a)(4).[14] Where good cause is shown, the only exception to the requirement to appoint a review panel is where the amount in controversy is less than $500. In that case, the Commissioner is not required to appoint a panel – but he must still conduct a hearing. Contrary to the assertion in the Petition, where good cause is shown, the Hawai'i statute does create a right to an external review hearing.

The fact that the Commissioner is authorized to dismiss a request for external review without hearing, where the Commissioner determines the request to be without merit, does not alter the fact that the external

---

[13] P. App. at 49a.

[14] P. App. at 48a.

review by a three-member panel is preempted by ERISA. This is equivalent to a dismissal for failure to state a claim upon which relief can be granted under Rule 12(b)(6) of the Federal Rules of Civil Procedure. The fact that a party's state law cause of action may be subject to dismissal without an evidentiary hearing, where on its face it is without merit, does not save that cause of action from preemption. Moreover, the statistics cited on pages 15 and 20 of the Petition for the number of external review requests rejected by the Commissioner were not brought to the attention of the state courts, and are thus not a part of the record in this case.

Petitioner suggests the Hawai'i court in *HMAA* erred in concluding that the preemption of the fee award provision of Haw. Rev. Stat. § 432E-6(e) necessarily followed from the preemption of the remainder of the Hawai'i statute. Petition at 18-19. Petitioner suggests the fee award provision ought to have survived as a part of the Commissioner's "power to assess sanctions as part of the regulatory function in policing compliance." *Id.* at 19. This argument was not presented to the state courts below. Moreover, Petitioner does not suggest how the Commissioner's exercise of his power to sanction could be warranted where the decision of the health plan is fully validated, as was the case in Petitioner's external review proceeding. In any event, the language of the statute clearly ties the award of attorneys' fees to the external review process. Haw. Rev. Stat. § 432E-6(e) ("An enrollee may be allowed . . . an award of a reasonable sum for attorneys' fees and costs incurred in connection with the

external review under this section").[15] The fee award provision properly fell with the remainder of the section.

The assertion at page 8 of the Petition that the Commissioner was only given the discretion to dismiss frivolous or meritless appeals in the 1999 amendments to the Hawai'i statute is contrary to the record. The provisions allowing the Commissioner to dismiss a request for external review under Haw. Rev. Stat. § 432E-6(a)(4) and (6) pre-existed the amendments to the statute in 1999 and 2000. *See* P. App. at 54a. Accordingly, there is no merit to Petitioner's assertion that the change to the title of the section from "Appeals to the Commissioner" to "External review procedure" suggests some change in the substantive right to a hearing. Petition at 9. The provisions allowing the Commissioner to dismiss a request for external review without hearing existed both before and after the title change.

Petitioner's argument that the primary purpose of the external review process is not to adjudicate the benefits due an enrollee who files a request for external review, but rather to "provide [the Commissioner] grist for his regulatory mill" is wholly unsupported by the statutory language. Petition at 4. Unless a request for external review is dismissed without hearing pursuant to Haw. Rev. Stat. § 432E-6(a)(4) or (6),[16] section 432E-6(a)(7) requires an adjudication based upon the facts of that case:

> The review panel shall review every final internal determination to determine whether the managed care plan involved acted reasonably.

---

[15] P. App. at 50a.

[16] P. App. at 48a-49a.

> The review panel and the commissioner or the commissioner's designee shall consider:
>
> (A) The terms of the agreement of the enrollee's insurance policy, evidence of coverage, or similar document;
>
> (B) Whether the medical director properly applied the medical necessity criteria in section 432E-[1.4] in making the final internal determination;
>
> (C) All relevant medical records;
>
> (D) The clinical standards of the plan;
>
> (E) The information provided;
>
> (F) The attending physician's recommendations; and
>
> (G) Generally accepted practice guidelines.

Haw. Rev. Stat. § 432E-6(a)(7).[17]

Contrary to Petitioner's assertion, the external review process under Haw. Rev. Stat. § 432E-6 is not simply an avenue for ensuring compliance with the requirement of section 432E-5(a) that a plan apply the medical necessity definition of Haw. Rev. Stat. § 432E-1.4 in its internal complaints and appeals process.[18] The issue to be decided by the review panel is whether the plan "acted reasonably," and the right to external review extends to "every final internal determination" of any "complaint," not only

---

[17] P. App. at 49a.

[18] P. App. at 46a.

those involving issues of medical necessity. Haw. Rev. Stat. § 432E-6(a)(7).[19]

Neither the language of the Hawai'i statute nor the record before the state courts support the novel interpretation of Haw. Rev. Stat. § 432E-6 which is advocated in the Petition. The Hawai'i court in *HMAA* fully and properly analyzed the Hawai'i external review statute in a manner consistent with controlling authority of this Court. Petitioner has demonstrated no basis for the Court to agree to hear this case.

III. THE PROCEEDINGS IN THIS CASE DO NOT REFLECT A CONFLICT BETWEEN THE STATES REGARDING AN IMPORTANT FEDERAL QUESTION

Although the Petition argues that the Hawai'i court misinterpreted the Hawai'i statute, the principal basis for seeking a writ of certiorari is the assertion that "[t]he Hawai'i court's decision in this case cannot be reconciled with the opinion of the Maryland Court of Appeals in *Conn. Gen. Life Ins. Co. v. Ins. Comm'r for Md.*, 371 Md. 455, 810 A.2d 425 (2002)." Petition at 21. However, that assertion ignores significant differences between the external review statutes of Hawai'i and Maryland, and the different analysis performed by the Hawai'i and Maryland courts. In truth, the two cases are distinguishable on both their facts and their analysis.

---

[19] The only complaints excepted from the external review process under the Hawai'i statute are claims of professional malpractice, negligence or fault. Haw. Rev. Stat. § 432E-6(b). P. App. at 49a. A separate external review procedure exists for those medical tort claims under Haw. Rev. Stat. Ch. 671.

The Maryland statute, unlike the Hawai'i statute, applies only to decisions regarding whether a service "is or was not medically necessary, appropriate or efficient." Md. Ins. Code Ann. § 15-10A-01(b)(1)(i) (definition of "adverse decision").[20] *See also id.* at §§ 15-10A-01(d) and (f) (defining "complaint" and "grievance" in terms of "adverse decisions");[21] Md. Ins. Code Ann. § 15-10A-02(d) (Commissioner to review "complaints" and "grievances");[22] Md. Ins. Code Ann. § 15-10A-03 ("Review of grievance decision").[23] By contrast, the Hawai'i statute provides for the review of any "final internal determination" of a managed care plan. Haw. Rev. Stat. § 432E-6(a).[24] The Hawai'i statute requires managed care plans to issue a "final internal determination" regarding any "complaint" by a member. Haw. Rev. Stat. § 432E-5(d).[25] A "complaint" is defined by Hawai'i law as "an expression of dissatisfaction, either oral or written." Haw. Rev. Stat. § 432E-1.[26] The reach of the Hawai'i statute is thus much broader than the Maryland statute, as it covers far more than medical necessity issues.

Further, the initial decision regarding medical necessity on an external review under Maryland law is made by the Commissioner, or by an IRO selected by the Commissioner. Md. Ins. Code Ann. §§ 15-10A-03(a) and (d).[27] There

---

[20] R. App. at 1a.

[21] R. App. at 2a.

[22] R. App. at 2a-3a.

[23] P. App. at 86a.

[24] P. App. at 47a. The only exceptions are medical tort claims, pursuant to Haw. Rev. Stat. § 432E-6(b). P. App. at 49a.

[25] P. App. at 46a.

[26] R. App. at 1a.

[27] P. App. at 86a-87a.

is no evidentiary hearing, unless one is requested by either party after reviewing the Commissioner's decision. Md. Ins. Code Ann. §§ 15-10A-03(e)(2) and (4) (specifying information to be considered by the Commissioner);[28] Md. Ins. Code Ann § 15-10A-04(a)(3).[29] This external review process much more closely resembles the Illinois statute upheld by this Court in *Rush Prudential* than does the Hawai'i statute. Under Hawai'i law, the first level of external review by the Insurance Commissioner involves an evidentiary hearing before a three-member panel, only one of whom is required to be a licensed physician. Haw. Rev. Stat. § 432E-6(a).[30] As noted above, Petitioner's assertion that the Hawai'i Commissioner has the option of referring an external review to an IRO rather than conducting a hearing before a three-member panel is contrary to the language and operation of the statute. Under the Hawai'i statute, a request for external review of a managed care plan's decision, which is not dismissed for lack of merit, is decided following an evidentiary hearing before a three-member panel – much like an arbitration. Haw. Rev. Stat. § 432E-6(a). *Id.*

It is true that both the Hawai'i and Maryland statutes provide for judicial review of the administrative decision rendered by the Insurance Commissioner. That is an aspect of the Hawai'i statute which was important to the Hawai'i court in deciding that Haw. Rev. Stat. § 432E-6 was preempted by ERISA. The Hawai'i court performed a detailed analysis of the conflict between the Hawai'i statute and the exclusive judicial enforcement scheme of

---

[28] R. App. at 4a.

[29] P. App. at 88a.

[30] P. App. at 47a.

ERISA, as contained in 29 U.S.C. § 1132(a). 106 Hawai'i at 31-36, 100 P.3d at 962-967. That same analysis, if applied to the Maryland statute, may well have resulted in a finding that the Maryland statute is preempted by ERISA. However, the decision of the Maryland court does not conflict with the decision of the Hawai'i court on this key point because the Maryland court did **not** perform a conflict analysis with respect to section 1132(a). Indeed, there is no indication in the Maryland court's decision that it was asked to conduct such a conflict analysis, or that either party had raised such an issue as part of the appeal. The majority of the Maryland court's analysis was devoted to its conclusion that the Maryland statute was saved from express preemption under 29 U.S.C. § 1144 as a statute regulating insurance. 371 Md. at 463-470, 810 A.2d at 430-433. The only conflict preemption analysis performed by the Maryland court was with respect to an ERISA regulation governing claims procedures *internal* to the plan, 29 C.F.R. § 2560.503-1. 371 Md. at 468, 471, 810 A.2d at 432, 434. That regulation has no bearing on whether a state process for *external* review, following the exhaustion of the internal review process afforded by a plan, is preempted by ERISA.

The Petition also asserts that a number of other states, in addition to Hawai'i and Maryland, have enacted "active enforcement" statutes, and argues the need for guidance to those states as a basis for the Petition. Petition at 24-26. It is not clear how the state courts of last resort in these jurisdictions would rule if presented with an argument that their external review statutes were preempted by ERISA. The state courts have not yet

spoken regarding this issue.[31] There are thus no conflicting decisions regarding the question of ERISA preemption of the statutes in those states which could justify the current Petition. Sup. Ct. R. 10(b). A conflict should not be assumed where the state's own courts have not yet had opportunity to speak on these issues. Even the law review article the Petition represents as discussing "the Missouri law's vulnerability to ERISA preemption" merely states that an ERISA preemption analysis should be conducted

---

[31] It is true that the other state statutes discussed in the Petition resemble the Hawai'i and/or Maryland statutes to varying degrees. However, Petitioner's assertion that these statutes have much in common with the Hawai'i statute fails to note the significant differences among the various statutory schemes. Missouri (R. App. at 5a) and New Mexico (P. App. at 91a-92a) review only issues of medical necessity, like the Maryland statute, while Delaware (P. App. at 93a-94a) and Michigan (P. App. at 96a) review a broad range of issues, similar to the Hawai'i scheme. The other state statutes cited by Petitioner are divided regarding whether the external review is on the record (Missouri, P. App. at 89a, and Michigan, R. App. at 9a-11a), or involves an evidentiary hearing (New Mexico, P. App. at 91a-93a, and, in some cases, Delaware). External review of medical necessity determinations in Delaware is performed by an Independent Utilization Review Organization ("IURO"), and thus likely does not involve a hearing. P. App. at 93a-94a. However, external review of issues other than medical necessity or the appropriateness of services is accomplished in Delaware through an arbitration process. R. App. at 7a-8a. The Delaware statute regarding such arbitrations provides for a hearing to be held. *Id.* With respect to judicial review, the decision following the external review is final and binding on the plan under three of the four statutory schemes (Missouri, P. App. at 89a; New Mexico, P. App. at 93a; Delaware, R. App. at 8a), but is binding on the member under only two of the statutes (Missouri, P. App. at 89a; New Mexico, P. App. at 93a). A decision upholding the plan's determination only gives rise to a rebuttable presumption in a subsequent action by a member in Delaware, thus appearing to preserve the ERISA remedy. R. App. at 8a. The Michigan statute expressly preserves remedies under state and federal law for the member, and under state law for the plan. R. App. at 12a.

by a prospective plaintiff. Gretchen Garrison, *House Bill 335-Managed Care in Missouri*, 66 UMKC L. Rev. 775, 797 (1998) ("An exhaustive discussion of ERISA preemption is beyond the scope of this article."). Accordingly, the only state court decisions before the Court on this Petition are the decisions of the Hawai'i and Maryland courts, and as discussed above, those decisions are easily distinguished. There is no conflict justifying a writ of certiorari.

Finally, the timing of the decisions rendered by the Hawai'i and Maryland courts provides a further basis for distinguishing the cases asserted to be indistinguishable by the Petition. The decision of the Maryland court was rendered before this Court issued its decision in *Aetna Health*, while the Hawai'i court had the benefit of that decision in performing its analysis. The guidance provided by the Court in *Aetna Health* for determining whether a state law would violate ERISA should resolve any confusion regarding the validity of the "active enforcement" external review schemes enacted in Hawai'i, Maryland, and the other states discussed in the Petition. As discussed above, *Aetna Health* confirmed that the preemptive effect of ERISA extends to any state law that "provides a separate vehicle to assert a claim for benefits outside of, or in addition to, ERISA's remedial scheme." 542 U.S. at __, 124 S. Ct. at 2500. If the state has provided "a separate vehicle to assert a claim for benefits outside of . . . ERISA's remedial scheme," that statute is preempted. It is not necessary for this Court to grant the Petition in order to provide additional guidance on that point.

CONCLUSION

For the foregoing reasons, Respondent Hawaii Management Alliance Association respectfully requests that the Court deny the petition for a writ of certiorari.

Respectfully submitted,

ELLEN GODBEY CARSON
Counsel of Record
DIANNE WINTER BROOKINS
ALSTON HUNT FLOYD & ING
18th Floor, ASB Tower
1001 Bishop Street
Honolulu, Hawai'i 96813
(808) 524-1800

Attorneys for Respondent
Hawaii Management Alliance
Association

HAWAII REVISED STATUTES

§91-9 Contested cases; notice; hearing; records. . . .

* * *

(g) No matters outside the record shall be considered by the agency in making its decision except as provided herein.

§432E-1 Definitions. As used in this chapter, unless the context otherwise requires:

* * *

"Complaint" means an expression of dissatisfaction, either oral or written.

MARYLAND INSURANCE CODE

§ 15-10A-01. Definitions

(a) In general. – In this subtitle the following words have the meanings indicated.

(b) Adverse decision. –

(1) "Adverse decision" means a utilization review determination by a private review agent, a carrier, or a health care provider acting on behalf of a carrier that:

(i) a proposed or delivered health care service covered under the member's contract is or was not medically necessary, appropriate, or efficient; and

(ii) may result in noncoverage of the health care service.

(2) "Adverse decision" does not include a decision concerning a subscriber's status as a member.

* * *

(d) Complaint. – "Complaint" means a protest filed with the Commissioner involving an adverse decision or grievance decision concerning the member.

* * *

(f) Grievance. – "Grievance" means a protest filed by a member or a health care provider on behalf of a member with a carrier through the carrier's internal grievance process regarding an adverse decision concerning the member.

(g) Grievance decision. – "Grievance decision" means a final determination by a carrier that arises from a grievance filed with the carrier under its internal grievance process regarding an adverse decision concerning a member.

§ 15-10A-02. Internal grievance process

* * *

(d) Filing complaints with the Commissioner. –

(1)(i) A member or a health care provider filing a complaint on behalf of a member may file a complaint with the Commissioner without first filing a grievance with a carrier and receiving a final decision on the grievance if the member or the health care provider provides sufficient information and supporting documentation in the complaint that demonstrates a compelling reason to do so.

(ii) The Commissioner shall define by regulation the standards that the Commissioner shall use to decide what demonstrates a compelling reason under subparagraph (i) of this paragraph.

(2) Subject to subsections (b)(2)(ii) and (h) of this section, a member or a health care provider may file a complaint with the Commissioner if the member or the health care provider does not receive a grievance decision from the carrier on or before the 30th working day on which the grievance is filed.

(3) Whenever the Commissioner receives a complaint under paragraph (1) or (2) of this subsection, the Commissioner shall notify the carrier that is the subject of the complaint within 5 working days after the date the complaint is filed with the Commissioner.

* * *

(f) Notification. – For nonemergency cases, when a carrier renders an adverse decision, the carrier shall:

(1) document the adverse decision in writing after the carrier has provided oral communication of the decision to the member or the health care provider acting on behalf of the member; and

(2) send, within 5 working days after the adverse decision has been made, a written notice to the member and a health care provider acting on behalf of the member that:

* * *

(v) includes the following information:

1. that the member or a health care provider on behalf of the member has a right to file a complaint with the Commissioner within 30 working days after receipt of a carrier's grievance decision;

2. that a complaint may be filed without first filing a grievance if the member or a health care provider filing a grievance on behalf of the member can demonstrate a compelling reason to do so as determined by the Commissioner[.]

§ 15-10A-03. Review of grievance decision

* * *

(e) Burden of proof. –

(1) A carrier shall have the burden of persuasion that its adverse decision or grievance decision, as applicable, is correct:

(i) during the review of a complaint by the Commissioner or a designee of the Commissioner; and

(ii) in any hearing held in accordance with § 2-210 of this article.

(2) As part of the review of a complaint, the Commissioner or a designee of the Commissioner may consider all of the facts of the case and any other evidence that the Commissioner or designee of the Commissioner considers appropriate.

* * *

(4) (i) Except as provided in subparagraph (ii) of this paragraph, in responding to a complaint, a carrier may not rely on any basis not stated in its adverse decision or grievance decision.

(ii) The Commissioner may allow a carrier, a member, or a health care provider filing a complaint on behalf of a member to provide additional information as may be relevant for the Commissioner to make a final decision on the complaint.

(iii) The Commissioner's use of additional information may not delay the Commissioner's decision on the complaint by more than 5 working days.

REVISED STATUTES OF MISSOURI

§ 376.1350. Definitions

For purposes of sections 376.1350 to 376.1390, the following terms mean:

(1) "Adverse determination", a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay or other health care service has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the payment for the requested service is therefore denied, reduced or terminated;

* * *

(6) "Clinical review criteria", the written screening procedures, decision abstracts, clinical protocols and practice guidelines used by the health carrier to determine the necessity and appropriateness of health care services;

* * *

(17) "Grievance", a written complaint submitted by or on behalf of an enrollee regarding the:

(a) Availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review;

(b) Claims payment, handling or reimbursement for health care services; or

(c) Matters pertaining to the contractual relationship between an enrollee and a health carrier;

DELAWARE STATUTES

16 Del. C. § 9119. Independent health care appeals program

(a) . . . For the purpose of this act, "medical necessity" means the providing of covered health care services or products that a prudent physician would provide to a patient for the purpose of diagnosing or treating an illness, injury, or disease or its symptoms, in a manner that is:

(1) In accordance with generally accepted standards of medical practice;

(2) Consistent with the symptoms or treatment of the condition; and

(3) Not solely for anyone's convenience.

The appeal review shall include any decisions regarding covered benefits by the covered person's health benefits plan, and any determination by the IURO shall be binding on the health carriers. If the IURO makes a determination in favor of the carrier, it will give rise to a rebuttable presumption to that effect in any subsequent action brought by or on behalf of the covered person with respect to the decision.

18 Del. C. § 332. Arbitration of disputes involving health insurance coverage

(a) The following definitions shall apply with respect to this section:

(1) "Adverse determination" means a benefit denial, reduction or termination, a denial of certification, or both.

(2) "Benefit denial" means the denial, in whole or in part, of payment or reimbursement for health care services rendered or health care supplies provided to any person claiming benefits under an insurance policy delivered or issued for delivery in Delaware.

* * *

(9) "Internal review process" or "IRP" means the procedure for an internal review of an adverse determination pursuant to subsection (b) of this section.

* * *

(e) With respect to adverse determinations that are subject to review by the Department of Insurance pursuant to § 9119(d) of Title 16, the Insurance Commissioner shall develop regulations providing for arbitration of such adverse determinations. Such regulations shall contain the following provisions:

(1) Requests for arbitration shall be in writing and mailed to the Commissioner within 60 days of the receipt of the written statement referred to in subdivision (c)(7) of this section.

(2) Arbitrators shall be chosen from an appropriate panel of arbitrators, and hearings shall be conducted according to rules established by the Department of Insurance.

(3) The arbitrator shall review written arbitration requests prior to holding any hearing or allowing any exchange of information between the parties in order to determine whether a written arbitration request is meritless on its face, and may summarily dismiss meritless requests for arbitration.

(4) Neither party shall be held to have waived any of its rights to seek relief in a court of law with respect to a covered person's legal rights to benefits by an act relating to arbitration or the rendering of an arbitration decision.

(5) Arbitration decisions shall be rendered within 45 days of the Commissioner's receipt of an arbitration request.

* * *

(g) If the arbitrator makes a decision in favor of the carrier, that decision shall give rise to a rebuttable presumption to that effect in any subsequent action brought by or on behalf of the covered person with respect to the decision. Should the decision favor the covered person, the carrier shall have the right to appeal the matter to the Court, in accordance with Court rules. The outcome of that appeal, however, shall have no effect on the covered person, as to whom the decision of the arbitrator shall control. The assignment of counsel for an appeal by the carrier and the payment of expenses of that assigned counsel shall be as set forth in § 9119(a) of Title 16.

MICHIGAN LAWS

§ 550.1903. Definitions.

* * *

Sec. 3. As used in this act:

(a) "Adverse determination" means a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay, or other health care service has been reviewed and has been denied, reduced, or terminated. Failure to respond in a timely manner to a request for a determination constitutes an adverse determination.

§ 550-1911 Request for external review; commencement; preliminary review; notice of acceptance; duties of commissioner; incomplete request; nonacceptance; assignment of independent review organization; duty of health carrier to provide documents; reconsideration by health carrier of its adverse determination; recommendation; considerations; review by commissioner; notice of decision.

Sec. 11. . . .

* * *

(7) . . . Except as otherwise provided in subsection (16), if the commissioner keeps a request, he or she shall review the request and issue a decision upholding or reversing the adverse determination or final adverse determination within the same time limits and subject to all other requirements of this act for requests assigned to an independent review organization. If at any time during the commissioner's review of a request it is determined that a request does appear to involve issues of medical necessity

or clinical review criteria, the commissioner shall immediately assign the request to an independent review organization approved under this act to conduct external reviews.

* * *

(9) Not later than 7 business days after the date of the notice under subsection (4)(b), the health carrier or its designee utilization review organization shall provide to the reviewing entity the documents and any information considered in making the adverse determination or the final adverse determination. Except as provided in subsection (10), failure by the health carrier or its designee utilization review organization to provide the documents and information within 7 business days shall not delay the conduct of the external review.

* * *

(11) The reviewing entity shall review all of the information and documents received under subsection (9) and any other information submitted in writing by the covered person or the covered person's authorized representative under subsection (4)(a) that has been forwarded by the commissioner. Upon receipt of any information submitted by the covered person or the covered person's authorized representative under subsection (4)(a), at the same time the commissioner forwards the information to the independent review organization, the commissioner shall forward the information to the health carrier.

* * *

(13) In addition to the documents and information provided under subsection (9), the reviewing entity, to the extent the information or documents are available and the

reviewing entity considers them appropriate, shall consider the following in reaching a recommendation:

(a) The covered person's pertinent medical records.

(b) The attending health care professional recommendation.

(c) Consulting reports from appropriate health care professionals and other documents submitted by the health carrier, the covered person, the covered person's authorized representative, or the covered person's treating provider.

(d) The terms of coverage under the covered person's health benefit plan with the health carrier.

(e) The most appropriate practice guidelines, which may include generally accepted practice guidelines, evidence-based practice guidelines, or any other practice guidelines developed by the federal government or national or professional medical societies, boards, and associations.

(f) Any applicable clinical review criteria developed and used by the health carrier or its designee utilization review organization.

* * *

(17) Upon receipt of a notice of a decision under subsection (16) reversing the adverse determination or final adverse determination, the health carrier immediately shall approve the coverage that was the subject of the adverse determination or final adverse determination.

§ 550.1915. Decision as final administrative remedy; other remedies.

Sec. 15 . . .

* * *

(2) Subsection (1) does not preclude a health carrier from seeking other remedies available under applicable state law.

(3) Subsection (1) does not preclude a covered person from seeking other remedies available under applicable federal or state law.